DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

# SUMMARY REPORT

# ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

## March 31, 2005

## PROCEDURE DISCUSSIONS

### Introductions and Overview

Pat Brooks welcomed the participants to the ICD-9-CM Coordination and Maintenance (C&M) Committee meeting. Approximately 200 participants registered to attend the meeting. This meeting marks the 20th year in which the Committee has been discussing ICD-9-CM updates. The procedure portion of the meeting was held on March 31, 2005 and was conducted by staff from the Centers for Medicare & Medicaid Services (CMS). The diagnosis portion of the meeting was held on April 1, 2005 and was conducted by staff from the National Center for Health Statistics, CDC. All participants introduced themselves. There were a wide range of participants representing hospitals, coding groups, manufacturers, physician groups, software vendors, and publishers, among others.

An overview of the C&M Committee was provided. All procedure code issues discussed at the March 31, 2005 meeting are being considered for implementation on October 1, 2005. A detailed timeline was included in the handouts. It was explained that the Committee meetings serve as a public forum to discuss proposed revisions to the ICD-9-CM. The public is given a chance to offer comments and ask questions about the proposed revisions. **No final decisions on code revisions take place at the meeting.** A summary report of the procedure part of the meeting will be posted on CMS' website at: http://www.cms.hhs.gov/paymentsystems/icd9. A summary report of the diagnosis part of the meeting will be placed on NCHS' web site at http://www.cdc.gov/nchs/icd9.htm. The public is offered an opportunity to make additional written comments by mail or e-mail until April 15, 2005. Should there be unresolved issues regarding the proposed procedure code revisions, the proposed changes will not be implemented on October 1, 2005. It may be necessary to address the issue again at the September 29- 30, 2005 meeting.

Comments on the **procedure** part of the meeting should be sent to:
Pat Brooks
Centers for Medicare & Medicaid Services (CMS)

CMM, HAPG, Division of Acute Care
Mail Stop C4-08-06
7500 Security Blvd.
Baltimore, MD 21244-1850
Patricia.brooks1@cms.hhs.gov

Comments on the **diagnosis** part of the meeting should be sent to:
Donna Pickett
NCHS
3311 Toledo Road
Room 2402
Hyattsville, MD 20782
Dfp4@cdc.gov

The participants were informed that this was strictly a coding meeting. No discussion would be held concerning DRG assignments or reimbursement issues. Comments were to be confined to ICD-9-CM coding issues.

CMS' ICD-9-CM homepage to be updated

CMS has updated their ICD-9-CM web page, http://www.cms.hhs.gov/paymentsystems/icd9. Detailed information is provided on the process of requesting a new or revised code. CMS implemented an online registration for the March 31 – April 1, 2005 meeting. This process appeared to work quite well. A link to the registration site is provided on the ICD-9-CM homepage. Alternatively, participants can go to http://www.cms.hhs.gov and click on "Events". A variety of CMS meetings can be seen and registered for at this site. **Participants can register for the September 29 - 30, 2005 meeting beginning June 29, 2005**. The registration site will close on September 23, 2005. Therefore, those who wish to attend the fall meeting must register online by September 23, 2005.

Process for requesting code revisions

The process for requesting a coding change was explained. The request for a procedure code change should be sent to Pat Brooks at least two months prior to the C&M meeting. The request should include detailed background information describing the procedure, patients on whom the procedure is performed, any complications, and other relevant information. If this procedure is a significantly different means of performing a procedure than is already described in ICD-9-CM, this difference should be clearly described. The manner in which the procedure is currently coded should be described along with information from the requestor on why they believe the current code is not appropriate. Possible new or revised code titles should then be recommended.

CMS staff will use this information in preparing a background paper to be presented at the C&M meeting. The CMS background paper includes a CMS recommendation on any proposed coding revisions. The background paper is distributed for discussion at the C&M meeting and referenced in the summary report. The background papers can be

viewed in their entirety on the CMS website at:
http://www.cms.hhs.gov/paymentsystems/icd9.

A presentation is made at the C&M meeting, which describes the clinical issues and the procedure. CMS staff will coordinate a discussion of possible code revisions. The participants at the meeting are encouraged to ask questions concerning the clinical and coding issues. Comments concerning proposed code revisions are taken for consideration. Final decisions on code revisions are made through a clearance process within the Department of Health and Human Services. No final decisions are made at the meeting.

**Next C&M Meeting**

**The next C&M meeting will be September 29 – 30, 2005. As stated above, the online registration for this meeting will begin on June 29, 2005 and close on September 23, 2005**, or earlier if registrations meet CMS room limitations. Due to fire code requirements, should the number of attendants meet the capacity of the room; the meeting will be closed to additional attendees. You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.

Those interested in attending the meeting should check the CMS' ICD-9-CM site for an agenda approximately one month prior to the meeting. Requests to have a topic considered at the meeting must be received two months prior to the meeting.

**April 1 code updates**

The participants were informed of an item in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that will impact the updating of ICD-9-CM. Section 503 (a) of the bill had language concerning the timeliness of data collection. The following clause was included:

"Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group (DRG) classification) under this subsection until the fiscal year that begins after such date."

The Centers for Medicare & Medicaid Services (CMS) discussed a proposal to accomplish this new congressional requirement in the Notice of Proposed and Final Rulemaking for the Hospital Inpatient Prospective Payment System. Information on this April 1 update process can be found in the Final Rule published August 11, 2004 (69 FR 48954) beginning on page 48954. In general, new diagnosis and procedure codes will be implemented on October 1, as has been standard practice. However, consideration will be given to implementing new codes on April 1 if a strong and convincing case is made by the requester at the fall C&M meeting that the new code is needed to describe new technologies. The public attending the fall C&M meetings will be given an opportunity to comment on the requestor's statement that the new code should be implemented on the following April 1.

The participants were informed that they should make known any requests for an April 1, 2005 code implementation at the fall meeting. If there are no such requests, the proposed codes discussed at the fall meeting would be considered for implementation on the following October 1.

A number of organizations and individuals have expressed concerns about the impact the April 1 ICD-9-CM coding update would have on providers. They pointed out that this would significantly impact their systems. For this reason, it is important that careful consideration be given as to whether or not a code for a new technology should be implemented on April 1. If a strong and convincing case were not made at the fall C&M meeting for an April 1 implementation, then the new code would be considered for a routine October 1 implementation. If there are no requests for an April 1 implementation of a specific code at the fall C&M meeting, then there would be no April 1 ICD-9-CM updates. All code revisions would be considered for October 1.

There were no requests for an ICD-9-CM code to be implemented on April 1, 2005 at this ICD-9-CM Coordination & Maintenance Committee meeting. Therefore, **there were no new ICD-9-CM codes implemented on April 1, 2005.**

**Topics:**

1. **Subtalar joint arthroereisis**

Robert Haralson, MD, FACS, made a clinical presentation on this procedure. Pat Brooks led a discussion on the coding proposal. One commenter stated that the American Hospital Association has received questions concerning how to code this procedure. The current code, 81.99, Other operations on joint structure, does not adequately describe the procedure. The commenter supported the creation of a new code. A physician commenter stated that the creation of a new code would provide data on the procedure that could be used to track clinical results. A commenter recommended that an excludes note be added to 81.13, Subtalar fusion, to exclude arthroereisis. One physician commenter expressed concern that the creation of a new code might encourage providers to perform the procedure instead of waiting for information on clinical outcomes.

2. **360 degree spinal fusion**

Robert Haralson, MD, FACS, made a clinical presentation on this procedure. Pat Brooks led a discussion on the coding proposal. One commenter representing a national organization of coders stated that she "absolutely applauded" CMS' recommendation of Option 3. She felt this would solve a number of problems surrounding the use of code 81.61, 360 degree spinal fusion, single incision approach, which has been quite confusing. Another commenter representing a national organization of hospitals also supported option 3 and thanked CMS for their work on this topic. The use of code 81.61 has created enormous confusion for coders. Data reported with this code is not valid

since the code has been subject to so much misinterpretation. Several other commenters supported the deletion of code 81.61. No one spoke in favor of maintaining the code. There was a consensus of opinion by those present that code 81.61 should be deleted. Several commenters supported option 2, which they felt would provide additional data on the specific nature of the fusion. Others felt that option 2 would continue to require coders to make decisions based on a review of operating room reports that exceed their training. One person stated that option 2 would create similar confusion to that currently found in the use of code 81.61.

3. **Hip replacement bearing surfaces**

James A. D'Antonia, MD, made a clinical presentation on this procedure. Pat Brooks led a discussion on the coding proposal. One commenter asked if the title of the new codes should be changed to "Joint bearing surface" so that the additional codes in the subsection could be used for other joints such as knees. Dr. D'Antonia stated that metal-on-metal and ceramic-on-ceramic would not be used for knee replacements. He did not see the value in creating more generic codes which could be used for other joints. Several commenters stated that they did not currently see documentation in the medical records that would allow coders to use these codes. One commenter asked if any manufacturers would start to provide documentation through labels which can be affixed to the medical records which would provide this information. One manufacture stated that they would explore creating such a label.

It was mentioned that the code also note states to "Code also type of bearing surface, if known." Therefore, if the information were not in the medical record, coders would not assign a code for the bearing surface. Several commenters supported this approach as opposed to the creating of an additional code for "unspecified" bearing surface.

Several commenters then expressed serious concerns about the "death of ICD-9-CM." By this they stated that the procedure coding book was running out of codes. There is only one section of 100 codes remaining in Section 17. One commenter stated that a policy should be created to severely restrict the creation of new codes so that the codes could last longer. Other commenters expressed frustration that the Department of Health and Human Services had not acted on recommendation of the National Committee for Vital and Health Statistics which recommended drafting a notice of proposed rulemaking for ICD-10-CM and ICD-10-PCS over a year and a half ago.

4. **Implantation of interspinous process decompression device**

Clifford B. Tribus, MD made a clinical presentation on this procedure. Pat Brooks led a discussion on the coding proposal. There were no comments for or against the creation of this new code. There was some discussion about where this procedure would be performed. Dr. Tribus stated that initially, many would be inserted in the inpatient setting. However, he felt the procedure would rapidly transfer to the outpatient setting.

5. **External fracture fixator devices**

Joel Tupper, MD, made a clinical presentation on this procedure. Ann Fagan led a discussion on the coding proposal. There were additional comments concerning the rapid loss of available codes for new procedures. Once again, commenters stated that CMS should carefully ration new codes since it did not appear that ICD-10 would be implemented any time soon. One commenter suggested that instead of using two sections of the remaining open section (17.00 – 17.99), CMS create only two codes for these external fracture fixator devices. One would be XX.XX Application of external fixator device, ring system. The other would be XX.XX Application of external fixator device, other multiplanar. The diagnosis codes and other procedure codes would then be used to determine to what part of the body the device was applied. There was support for this more streamlined approach. One commenter suggested that if codes are added, CMS could create them in subsection 84.9, Other operations on musculoskeletal system, to remain in the same body system. That would leave the 17.XX codes available for other uses.

6. **Infusion of liquid radioisotope**

Joe Kelly, MD made a clinical presentation on this procedure and led a discussion on the coding proposal. Several commenters supported Option 2 which created three new codes. One commenter suggested that the following be added:
01.26 Insertion of catheter into cranial cavity
Code also any resection
Includes creation of burr hole, if necessary.

01.27 Removal of catheter from cranial cavity
Includes repair of cranial defect

7. **Safe-Cross Radiofrequency Total Occlusion Crossing System**

Geoffrey Hartzler, MD, made a clinical presentation on this procedure. Ann Fagan led a discussion on the coding proposal. There was support for the creation of a new code to capture this procedure. One commenter suggested removing the term "Radiofrequency" from the title, and suggested an alternative code title:
00.66 Direct ablation of total vessel occlusion(s).

Other commenters agreed with the suggestion to make the code more generic, as other devices may not use radiofrequency, but may use ultrasound, microwave, or laser to accomplish the same result. It was felt that the more generic title would be more flexible in capturing future developments in this area. One commenter who supported the new code at 00.66 stated that the excludes notes under category 00.6 would have to be modified to put this procedure at 00.66 so that this code could be used when performed in conjunction with an angioplasty or a stent insertion.

8. **Endovascular implantation of graft in thoracic aorta**

Richard Cambria, MD, made a clinical presentation on this procedure. Ann Fagan led a discussion on the coding proposal. Several commenters supported this new code. One commenter recommended that the inclusion terms be modified to make them more specific to this code. For instance, the term Endograft(s) should be changed to Endograft(s) of thoracic aorta. The commenters supported capturing this distinctively different procedure.

9. **Immunosuppressive Antibody Therapy during induction phase of solid organ transplantation**

Ken Brayman, MD, made a clinical presentation on this procedure. Joe Kelly, MD, led a discussion on the coding proposal. Several commenters supported the creation of a new code at 00.18 Infusion of immunosuppressive antibody therapy during the induction phase of solid organ transplantation. One commenter questioned how many times the code would be reported for a single admission. The answer was that a patient could be given multiple infusions during one admission. One person then asked whether a note should be included to state that the code included multiple infusions. Others thought that hospitals would report the code each time it was performed. Another commenter recommended that a note not be added stating that the code included multiple infusions. This commenter felt the matter should be left to the discretion of the individual coder. If a patient had multiple procedure codes, there would be a decision made on how many times the code would be reported.

10. **Addendum**

Ann Fagan led a discussion on the addendum proposal. There was support for the addendum and no opposition.

11. **ICD-10-PCS**

Thelma Grant provided an update on ICD-10-PCS update and maintenance activities. A PowerPoint presentation of her discussions is posted on the CMS web page.

This ended the procedure part of the ICD-9-CM Coordination and Maintenance Committee. The meeting was adjourned. The diagnosis part of the meeting was to take place on April 1, 2005 and would be led by the National Center for Health Statistics. A Summary Report of the Diagnosis Topics can be found at:
http://www.cdc.gov/nchs/icd9.htm